KIM THOMPSON

YOGA AND WELLNESS

WFC LLC

Assisted Stretch Intake and Waiver

*** This form is required to be turned in at least 48 hours prior to your first scheduled appointment. If less than 48 hours, your appointment may be rescheduled.*

Full name and today's date

DOB

Address

Address line 2

Phone

Email

Referred by

Do you have a current exercise routine? Please explain below:

Fitness or stretching goals:

Are there specific areas of the body you'd like to focus on?

What percentage of your day is spent sitting/driving/performing physical labor?

Have you previously seen or are currently seeing a Chiropractor? If yes, frequency and last visit date:

Have you ever gotten a massage? If yes, frequency and last visit date:

Do you believe physical flexibility is an important part of fitness and overall health? Y N

Are you currently under the care of a physician? Y N

If there are any diagnosed health issues or any other physical concerns, or medications your practitioner should be aware of, please list them below:

Relevant injuries and/or surgeries (including dates):

Emergency contact person. Please include name, relationship, and phone number:

Acknowledgment, Waiver, and Release

1. I understand that assisted stretching involves risk of injury and I am fully aware of the risks and injuries involved.
2. I understand that it is my responsibility to consult with a physician prior to and regarding my participation in any activity, included assisted stretching. As such, I further understand that any information provided by BYS is not to be followed without the prior approval of my physician and that assisted stretching is no substitute for physical therapy or any other physician prescribed treatment. I further understand that Assisted Stretch Practitioners do not diagnose, prescribe, or treat physical or mental illness. I represent and warrant that I have no medical condition that would prevent my full participation in any activity and to inform the practitioner immediately if an injury occurs.
3. In consideration of being permitted to participate in assisted stretching, I agree to assume full responsibility for any risks, injuries or damages, known and unknown, which I might incur as a result of participating in this activity.
4. In further consideration of being permitted to participate in assisted stretching, I knowingly, voluntarily, and expressly waive and release any claim I may have now or may have in the future against WFC and/or its Practitioners and hold them harmless from any loss or liability in connection with my participation.
5. I certify that I am at least 18 years of age.

Policies:

- Kindly note there is a 48 hour rescheduling or cancellation policy. If an appointment is canceled within 48 hours of the scheduled appointment, you will be responsible for the costs of the session.
- Grip socks are required for your and the therapist's safety. Otherwise, stretchy and comfortable clothes are appropriate.
- Please arrive 15 minutes early to your session and silence cell phones.
- Pain or discomfort during your session should be communicated immediately to your practitioner so adjustments can be made. Residual soreness (24-48 post stretch) is normal. If the pain is excessive, please contact your physician or call 911.
- The purpose of these sessions are designed to assist in greater stretch gains.
- In signing this document, I acknowledge and represent that I have read it and fully understand its contents. I voluntarily agree to the terms and conditions stated above.

Printed name

Signature and date